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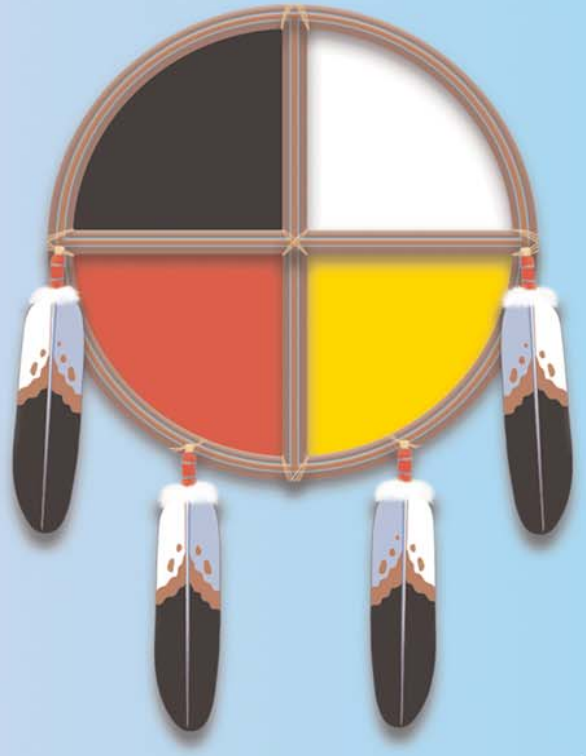
NATIONAL SUICIDE HOTLINE NUMBER

TOLL-FREE NATIONWIDE U.S.A.
24 HOURS / 7 DAYS A WEEK
1-800-(784-2433) (SUICIDE)
1-800-273-(8255) (TALK)

INDIAN HEALTH SERVICE

NATIONAL SUICIDE PREVENTION COMMITTEE



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SUICIDE PREVENTION

Statement of Purpose

To develop, advocate for, and coordinate a comprehensive cultural- and community-based approach to reduce suicidal behaviors and suicides in AI/AN communities.

INTRODUCTION

Peter Stuart, MD, Member, National Indian Health Service Suicide Prevention Committee (SPC), and Chief, Mental Health Services, Chinle Service Unit, Navajo Area Indian Health Services, Chinle, Arizona

Suicides and suicide-related behaviors exact a profound toll on American Indian and Alaska Native (AI/AN) communities. Despite the gains made in other areas such as infectious disease and infant mortality, suicides and their cousins, homicides and accidental death, are synonymous with the wrenching cultural dislocation and widespread poverty many indigenous communities continue to experience. Suicides reverberate through close-knit communities and continue to affect survivors many years after the actual incident.

With death rates 2 - 3 times the national average across all Indian country, particularly for young and working age AI/AN males, and rates approaching epidemic proportions in some AI/AN communities, and with suicide always being among the top ten causes of mortality for those under age 55, reducing suicide is a task requiring urgent and dedicated attention.

In 2003, the Indian Health Service (IHS), under the aegis of Dr. Charles Grim, chartered the IHS Suicide Prevention Committee (SPC). The committee was tasked with identifying and defining the steps needed to build on the suicide prevention efforts of the past in order to significantly reduce the impact of suicide and suicide-related behaviors on AI/AN communities. Members of the committee were selected to represent affected AI/AN communities in the broadest fashion possible. They included therapists, school superintendents, psychologists, psychiatrists, agency administrators, injury prevention specialists, social workers, and traditional practitioners from a broad geographic distribution and from mixed IHS, tribal, and urban settings. The committee met both face-to-face and by phone and sought consultation from a variety of sources in developing what is now known as the IHS National Suicide Prevention Committee Work Plan.

The plan follows, in many aspects, the National Strategy for Suicide Prevention, a national initiative to reduce the impact of suicide and suicide-related behaviors. It will be revised over time as tasks are accomplished and further tasks identified. At its best, the plan will be a living and constantly changing reflection of the collaborative and focused efforts of the many people throughout AI/AN communities who are working to reduce the scourge of suicide.

Guiding principals for the IHS Suicide Prevention Committee

WORK PLAN

We care. We love. We respect. Sung, spoken, or prayed, healing the affliction of suicide in all AI/AN communities starts with these six simple words. Throughout this work plan, we strive to be respectful to tribal and urban American Indian/Alaska Native communities and cultures. We intend this plan to be grounded in spirituality and to incorporate collaboration, care, and healing into the plan through culture. We want to help tribal and urban communities access their own spiritual, mental, emotional, and physical strengths. We believe suicide occurs to and in communities, that suicide is an act rooted in the history of a particular person, family, and people, and that to root it out will require the best holistically and culturally wise, collaborative efforts our communities and the bureaucracies that serve them can muster. We believe that our work must recognize the historical impact of colonization on our people and must incorporate this understanding into our efforts if our work is to succeed for future generations. We believe that helping communities keep all of their members in the circle and promoting communication between families, community members, and organizations is critical to reducing suicide.

With these principles in mind, we hope to provide a holistic, cultural foundation to suicide prevention, building on the strong resilience of American Indian/Alaska Native communities. We will strive to bridge concepts between American Indian/Alaska Native communities and bureaucracies in order to effectively prevent suicide.

The work plan covers three broad areas of interest and is correlated with the National Strategy for Suicide Prevention (NSSP). These areas are as follows: Awareness (NSSP Goal 1); Interventions (NSSP Goals 4, 6, and 7); and Methodologies (NSSP Goals 10 and 11).

WORK PLAN OUTLINE

Awareness — Community Education and Outreach (NSSP Goal 1: Promote awareness that suicide is a public health problem that is preventable)

Guiding Principle: Collaboration with other agencies, providers, and organizations to share information and resources by promoting awareness that suicide is preventable.

- Addressing the stigma by desensitizing "seeking help"
- Developing awareness education for various groups (including law enforcement, school personnel, survivors, foster parents, and others)
- Disseminating information via the Internet for a broad audience

Objective 1: Recommend the designation of an IHS/SPC Public Awareness Coordinator to assist communities in tailoring public awareness information for their communities. Designate an IHS/SPC Coordinator of Public Awareness to take charge of a national public awareness campaign on suicide prevention. Consider establishment of a new position at the national level. Coordinator to work in collaboration with established programs such as HP/DP to implement campaign. *Discussions are underway through collaboration with the National Indian Health Board to identify funds for a national coordinator position. Initially, the function will be contracted out to already existing behavioral health contracts to initiate development of public media materials.*

Objective 2: Have resources and ideas on public awareness campaigns available on the IHS website under the IHS/SPC. *A contract for website design and maintenance is active as part of a larger multinational effort to develop a website for indigenous suicide prevention.*

WORK PLAN OUTLINE Continued...

Interventions — Clinical Assessment and Treatment (NSSP Goal 6: Implement training for recognition of at-risk behavior and delivery of effective treatment; NSSP Goal 7: Develop and promote effective clinical and professional practices)

Objective 1: Identify, involve, and train those programs that are vital to a Suicide Prevention Program that encompasses the life span. This may include prenatal and well-child programs, maternal/child health, school-based health programs, residential and non-residential schools, Indian Child Welfare Act support programs, alcohol/drug programs, juvenile detention, juvenile court, Temporary Aid to Needy Families programs, vocational rehabilitation programs, Tribal and Cooperative Housing Authority programs, law enforcement, regional youth drug programs, alternative schools, Boys and Girls Clubs, churches, shelters, Community Health Representatives, Elder and Senior Centers, Emergency Medical Services, and others.

Through an interagency agreement with SAMHSA, IHS has initiated the development of a community suicide prevention toolkit and is supporting the establishment and training of a group of selected IHS and tribal providers in all IHS Areas to assist in response to suicide crises and community suicide prevention programming. Next steps include broadening the application of these tools to include individual communities and developing an active network of participating communities.

Objective 2: Provide comprehensive, multidisciplinary training to enhance clinical, professional, and culturally competent practices to include:

- Screening
- Assessment
- Case management
- Intervention
- Legal/ethical concerns in practice
- Survivor issues

See Objective 1. In addition, suicide prevention has been included as a particular focus area in the national IHS/SAMHSA BHS meetings for the past two years, as well as being included in IHS Injury Prevention Seminars offered to a national audience.

Objective 3: Encourage each I/T/U community to identify a coordinator(s) of the suicide prevention training activities. *Ongoing.*

Objective 4: Provide samples of screening/assessment/ intervention tools, case management procedures, and legal/ethical issues. *Samples of suicide intervention/prevention policies have been made available at national BHS conferences and through the combined IHS/SAMHSA training project (contact Kira LeCompte, Aberdeen Area BHS for details). Further policies and tools are being reviewed and will be available through the web once the website development is completed.*

Objective 5: Develop support services/after care for ongoing support to survivors (extended family, service providers/first responders). *Survivor groups remain underutilized. Funding and training for these groups is needed.*

WORK PLAN OUTLINE Continued...

Interventions – Community Programming (NSSP Goal 4: Develop and implement community-based suicide prevention programs)

Objective 1: Develop and put in place workable, community-owned suicide prevention plans that include all responsible parties within the service area.

A. Provide samples of community assessment/community readiness models that have been used in Indian communities. Distribute on the Internet, at conferences, and by regular mail. *The Community Readiness Model developed by Plested, Edwards and Jumper-Thurman has been distributed widely and has been presented in a variety of AI/AN training venues. Other models, including the Public Health Model, are available and have demonstrated effectiveness.*

B. Identify federal/state/local technical assistance teams and seek the support and endorsement of the Director of the Indian Health Service to facilitate the development of community action plans to specifically address suicide prevention/intervention. *This should be a major area of emphasis for 2006.*

C. Promote community and tribal leaders' involvement in the assessment process and development of the Suicide Prevention Community Action plans. *See B above.*

D. Develop a draft "Dear Tribal Leader" letter for Dr. Grim's signature requesting tribal support of the IHS Suicide Prevention Initiative's Objectives. *See the September 9, 2003 letter to tribal leaders announcing the Suicide Prevention Initiative. A follow-up letter is planned in coordination with the establishment of the community suicide prevention website and website availability of the suicide surveillance system.*

WORK PLAN OUTLINE Continued...

Methodology – Research (NSSP Goal 10: Promote and support research on suicide and suicide prevention)

Guiding Principle: Understand the interaction of sociocultural, historical, economic, biologic, and spiritual factors contributing to suicide from an AI/AN perspective.

Objective 1: Support culturally competent researchers who work in collaboration with communities through establishment of protocols for engaging with communities and who provide direct services to tribal members.

A. Promote tribal oversight of IRBs for research and related activities. *This is an institutional priority.*

B. Assist tribes in reviewing and approving research as requested. *Available as requested.*

C. Develop criteria for cultural competence in behavioral health practice. *SPC members have participated in national collaborative efforts to define and strengthen cultural competence in BH care over the past two years. Next steps for 2006 include increasing awareness for I/T/U providers of these criteria and facilitating regional and local discussions on their practical application and implementation.*

D. Ask that all IHS Behavioral Health Service meetings include 1) student scholarships and 2) opportunities for students to meet with AI/AN professionals. *The SPC has asked at the national level that any IHS sponsored general trainings (such as the IHS/SAMHSA BH conference) include student scholarships. At the 2005 San Diego conference, this discussion included extending such opportunities to high school students, as well as students pursuing college or postgraduate training. A more formalized process is needed to ensure that opportunities exist for professionals-in-training to meet with established professionals to facilitate mentoring and support.*

E. Support AI/AN researchers in maintaining tribal ties in the process of their professional development. *This is an ongoing advocacy issue, and the SPC offers its support to any graduate or postgraduate students encountering difficulty negotiating a learning context that allows continued contact with their tribal communities of origin.*

Objective 2: Develop a prioritized research agenda that reflects the complexity of suicide in AI/AN Communities. *An international meeting, in collaboration with NIMH, on suicide prevention among indigenous groups is scheduled for September 22 - 24 in Albuquerque in part to help refine an American Indian/Alaska Native research priority list. The main purpose of the conference is to facilitate community feedback to researchers regarding appropriate research topics and goals as they pertain to suicide and suicide prevention.*

Objective 3: Develop and distribute epidemiologic data on mental health disorders in AI/AN populations, with a focus on suicide. *This remains an issue of some concern. Data now exist on the distribution of mental health disorders in a variety of tribal groups from a large-scale epidemiologic survey completed in the early 2000s (Manson, and others). Further work is necessary to encourage the broad distribution of these data to interested and affected tribal communities. In addition, work continues on the national IHS suicide surveillance system (see article by D. Grenier in this edition for details). This system should provide increased information about suicide and suicide-related behaviors and assist in focusing and evaluating efforts to reduce suicide.*

WORK PLAN OUTLINE Continued...

Methodology – Surveillance (NSSP Goal 11: Improve and expand surveillance systems)

Objective 1: Establish a national consensus on a working definition of suicide and suicide related behaviors and coordinate with a consistent reporting and data analysis process. *See Objective 2 under Methodology: Research. The IHS Suicide Surveillance System has defined many of these parameters in practice. Ongoing discussion will be necessary once data are being regularly reviewed and analyzed at the national, regional, Area, and local levels. ÿ*
Objective 2: Support reporting requirements for contracted/compacted programs to report data back to IHS. *The SPC has formally requested reporting requirements.*

Methodology – Best Practices

Objective 1: Develop a centralized clearinghouse for AI/AN behavioral health concerns including suicide. *A contract is in place to establish an internationally available clearinghouse for information on suicide prevention.*
This work plan was approved by the Indian Health Service Suicide Prevention Committee in December 2004. Members of the committee include Robert Beasley, Nancy Bill, Susan Casias-Oliver, Rose Clark, Eduardo Duran, Marlene Echohawk, Iva Graywolf, Kira LeCompte, Hayes Lewis, Kathy Moon, Peter Stuart, and Jackie Vorpahl.

Next Steps
The SPC continues to meet regularly. For the remainder of 2005 and early 2006, the emphasis will be on facilitating implementation of the above objectives. Additional objectives will be developed. The focus will continue to be on approaching suicide as occurring to individuals strongly embedded in larger communities. Interventions early in the lifespan that enhance resiliency and community and family support are specifically encouraged.
Schools, in particular, are likely to be targets of such efforts, given their broad ranging involvement in student, family, and community life. Continued support of the suicide surveillance system will be critical in terms of understanding the affected groups better and being able to monitor outcomes.
Finally, an underrecognized population that has had few, if any, efforts directed towards establishing prevention programming are males from adolescence through midadulthood. Understanding this group and developing targeted programming is essential to any long-term success in reducing suicide completion rates.

Summary
Suicide is a complicated public health challenge with a myriad of contributors in AI/AN communities. Only the pursuit of a multitargeted, coordinated, and persistent effort that is acutely aware of the cultural context of suicide and blends the best of traditional AI/AN healing wisdom and western public health tools is likely to succeed on a national basis.

Bibliography
1. National Strategy for Suicide Prevention: Goals and Objectives for Action, DHHS, Public Health Service, 2001.
2. Trends in Indian Health 1998-99, DHHS, Indian Health Service, 2000.
3. Reducing Suicide – A National Imperative, Goldsmith et al, Institute of Medicine, The National Academies Press, Washington DC, 2002.

Suicide Prevention Policy Statement in Indian Country

The Role of the Indian Health Service in responding to Suicide Crisis in Indian Country

POLICY STATEMENT

It is the responsibility of the IHS Suicide Prevention Committee (SPC) to provide policy recommendations and guidance to the Indian Health Service regarding suicide prevention and intervention in Indian Country.

The role of the Indian Health Service in suicide prevention and intervention is to:

1. Facilitate communication and collaboration with and among all national agencies, tribes and internally as regional and local organizational units of the Indian Health Service to coordinate responses and resources within Indian Country.

2. Consult with tribes and the IHS SPC to develop protocols to identify response teams, orientation, scheduling logistics and allocation of resources to tribal sites that experience suicide emergencies.

3. Advocate for funds from funding authorities and resources, identify funds for primary and secondary suicide prevention programs and prioritize early prevention as the most important type of programming. Funding priorities should reflect a focus on developing & promoting resiliency and community support.

4. Ensure that an active suicide surveillance system is in place throughout Indian Country.

5. Sponsor national and regional meetings and conferences on best practices in suicide pre vention and intervention.

6. Establish national program standards for community suicide prevention.

7. Review and monitor federally-funded programs of national scope to prevent suicide in Indian Country.

8. Coordinate a national research agenda and communicate the agenda to all IHS levels, partner agencies and Indian Country.

9. Monitor policy implementation and compliance among all organizational levels and among partner agencies.

STRUCTURE

IHS SUICIDE PREVENTION COMMITTEE
COMMITTEE STRUCTURE POLICY

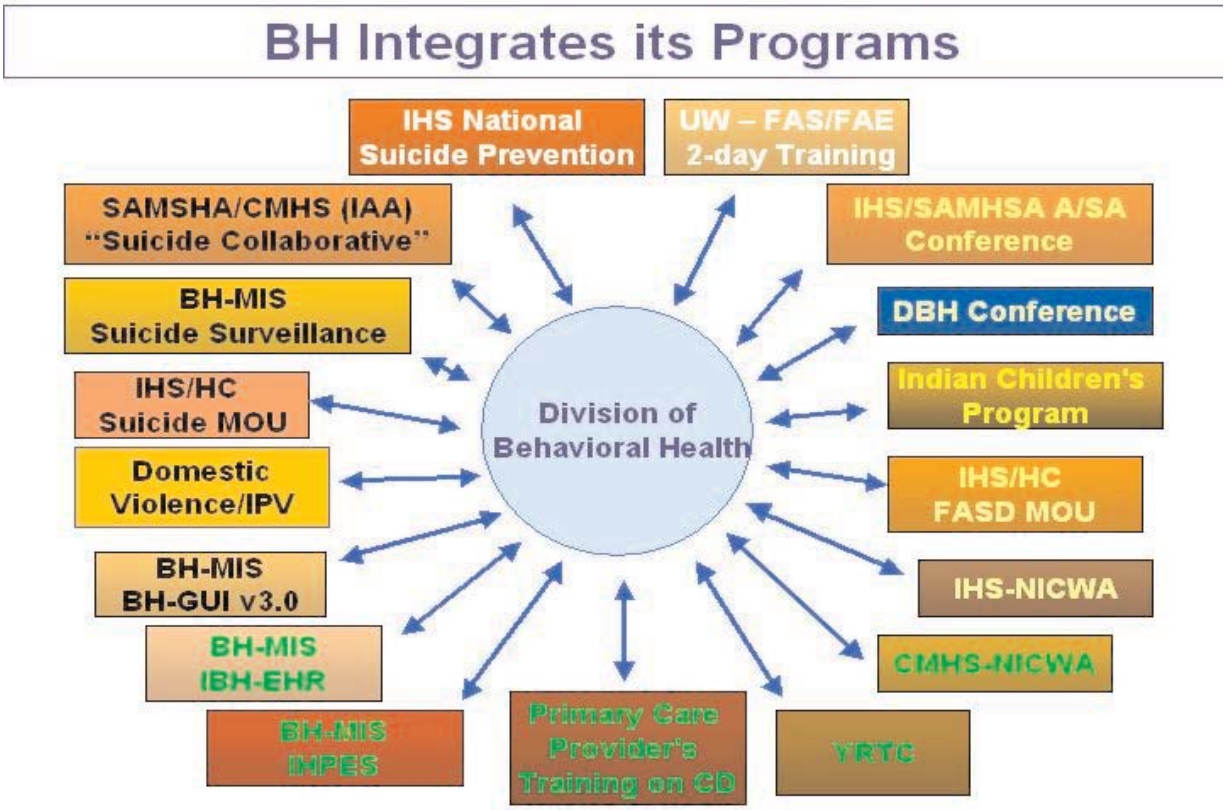
Purpose:

To define the structure of the IHS Suicide Prevention Committee.

Procedure:

1. Membership of the committee consists of:
    a. 1 Representative from IHS Headquarters
    b. 9-11 members at large selected based on geographic representation (including urban areas), discipline expertise, community representation, tribal affiliation, and gender.
2. Nomination process:
    a. The committee solicits nominations from interested and involved parties working on suicide prevention among Native American/Alaskan Native populations. Nominations are reviewed through a formal review process as needed to fill vacancies.
3. Length of term:
    a. 3 years
4. Committee Management:
    a. A chair, vice-chair and secretary are selected by committee census. Selections are made by the committee as needed.
5. Participation Requirements:
    a. Monthly conference calls and bi-annual face-to-face meetings.
6. Reports to:
    a. Director, IHS
        1. Director, BH Services, IHS annually or as needed.

SPC SLIDES


BH Integrates its Programs
IHS National Suicide Prevention
UW – FAS/FAE 2-day Training
SAMSHA/CMHS (IAA) "Suicide Collaborative"
IHS/SAMHSA A/SA Conference
BH-MIS Suicide Surveillance
DBH Conference
IHS/HC Suicide MOU
Indian Children's Program
Division of Behavioral Health
Domestic Violence/IPV
IHS/HC FASD MOU
BH-MIS BH-GUI v3.0
IHS-NICWA
BH-MIS IBH-EHR
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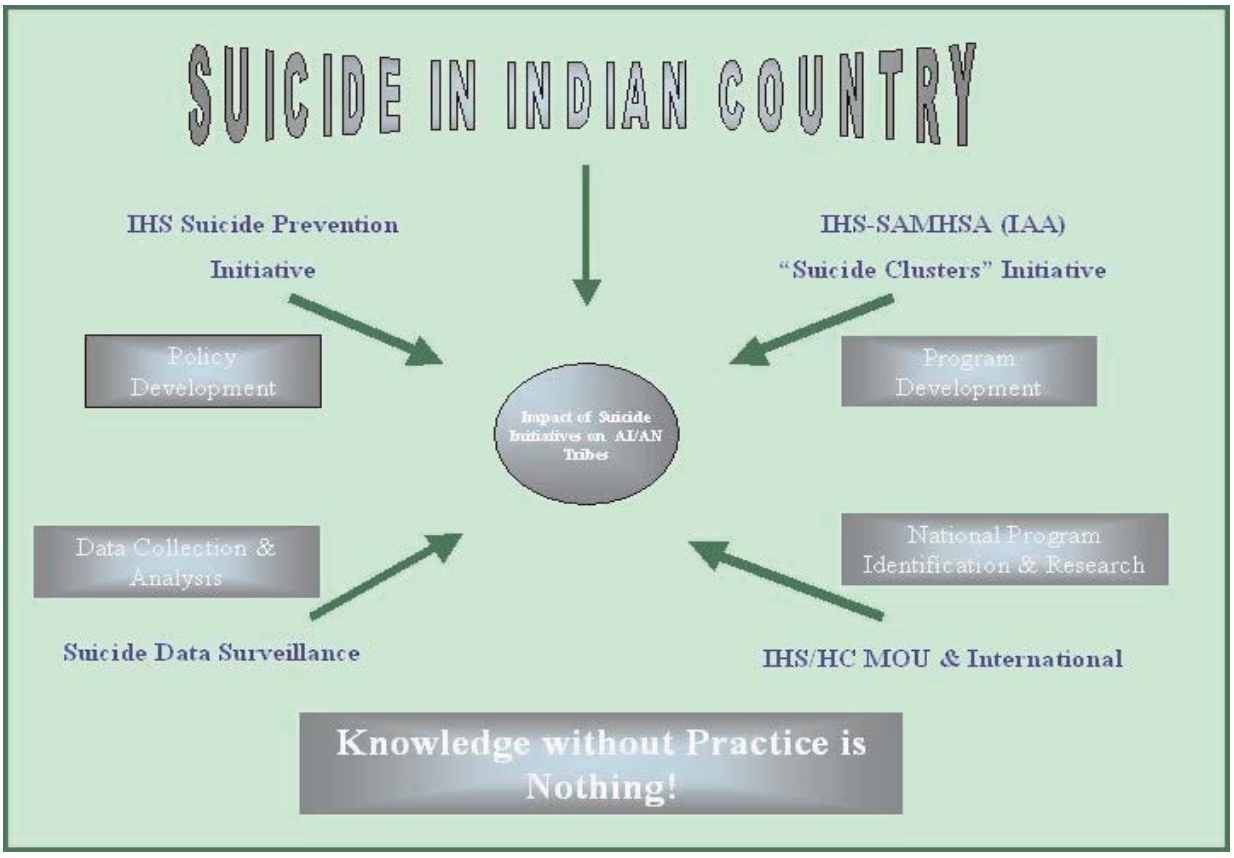
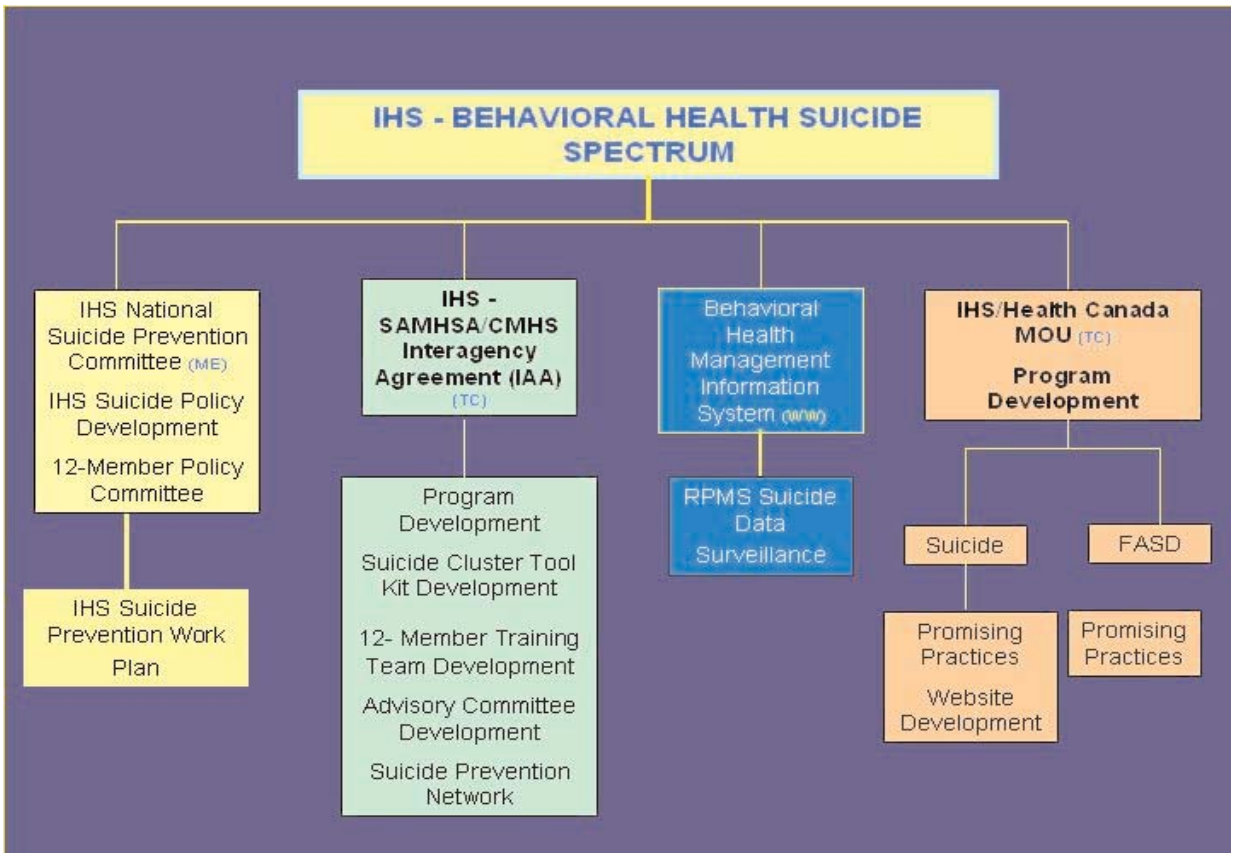
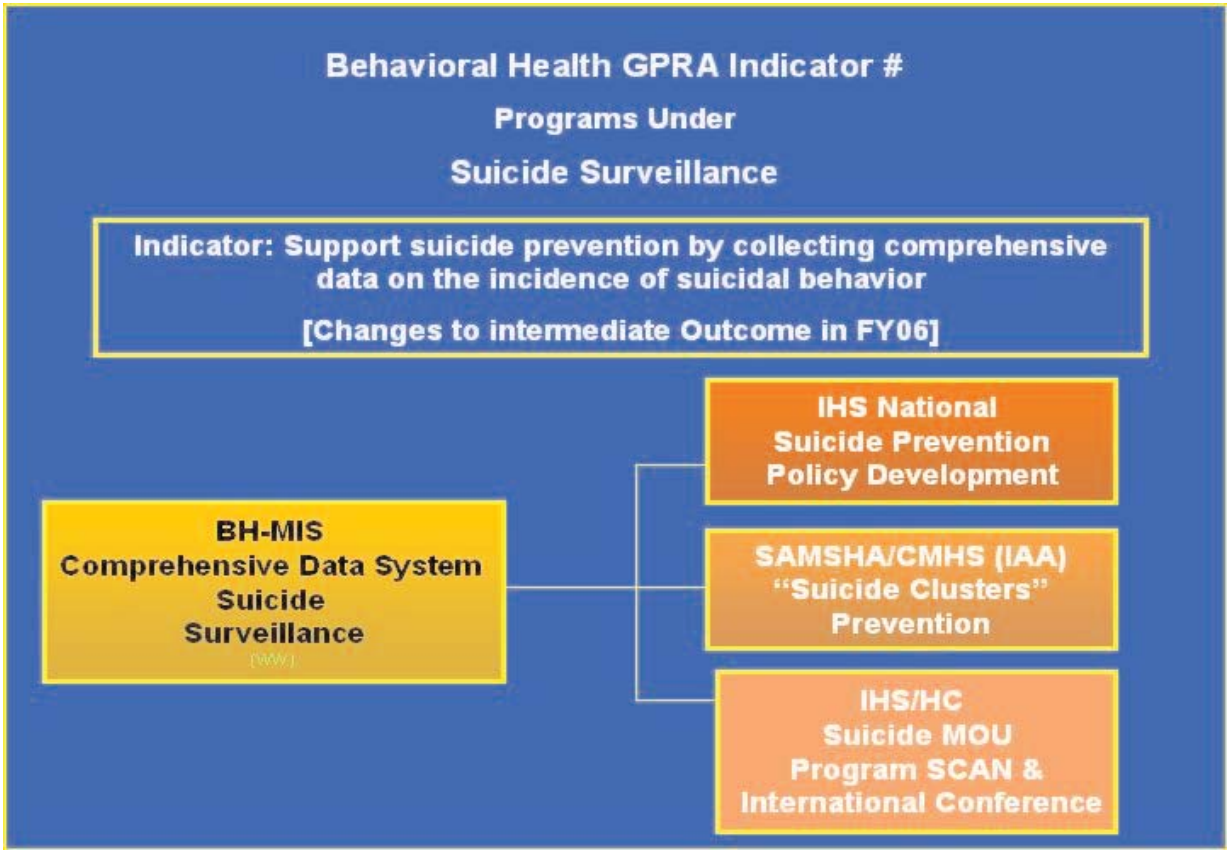
Primary Care Provider's Training on CD
YRTC


SUICIDE IN INDIAN COUNTRY
IHS Suicide Prevention Initiative
IHS-SAMHSA (IAA) "Suicide Clusters" Initiative
Policy Development
Program Development
Impact of Suicide Initiatives on AI/AN Tribes
Data Collection & Analysis
National Program Identification & Research
Suicide Data Surveillance
IHS/HC MOU & International
Knowledge without Practice is Nothing!

SPC SLIDES Continued





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